A Report:

Comprehensive Healthcare Services for Under and Uninsured Leon County Residents

And

A Proposed "Strawman"

Comprehensive Healthcare Services Model

Primary Healthcare Implementation Advisory Board
December 8, 2005

A Report on

Comprehensive Healthcare Services for

Under and Uninsured Leon County Residents

The people of Leon County, along with those in many other parts of the nation, are facing a major health care cost crisis. The costs of health care have risen to the point that many of the County's employers can no longer afford to provide health insurance benefits for their employees, and the employees can no longer afford to purchase individual health insurance policies. The result has been:

- a continuing increase in the number of low income County residents who have no health insurance and are not eligible for any publicly funded health care program, such as Medicare or Medicaid;
- rapid growth in the number of low income, uninsured residents who seek health care at the County's two hospital emergency rooms resulting in a rapid growth in the uncompensated costs for the two hospitals; and
- rapid growth in insurance costs as the hospitals and other County health care providers are forced to charge higher prices to insured payers to cover the uncompensated costs for those who cannot pay.

Health insurance in Florida is a complex issue, affected by a wide range of factors, including economic fluctuations and cultural traditions. For example:

- There are many reasons that those born outside the U.S, are at greatest risk of uninsurance. Most recent immigrants do not qualify for government-sponsored programs, and the service jobs available to immigrants are the least likely to offer health coverage through the workplace. Additionally, the immigrant's native country may not have a tradition of health coverage.
- The significant decrease in uninsurance among preschoolers and slight decline in uninsurance among older children is attributable to the state's highly regarded and successful children's programs, which make publicly supported coverage available to children in working families of low and modest income, through Medicaid and related programs.
- More than a third (35.1%) of young working-aged adults (age 19 to 24) are without coverage. Some of this is due to their decision to decline coverage. But it is also due to being on the unfavorable side of two-tier wage agreements, or the fact that

many young workers are forced to take entry-level positions without benefits (as temporary workers, substitute teachers, or contract hires).

Clearly, there are many different reasons that people are without health insurance. No one number or percentage tells the whole story. Indeed, more thorough, multivariate analyses of these data and several subsequent reports will emerge over the coming months. In collaboration with AHCA and Health Management Associates, the additional survey findings will be combined with information obtained in focus groups and reviews of action taken in other states, all intended to help understand the complicated reality of why and how people obtain health insurance coverage (or not).

Florida took important steps in 2003 by creating the Governor's Task Force on Access to Affordable Health Insurance, and the House Select Committee on Affordable Health Care for Floridians. Some Policy directions were established and legislation was enacted in several areas.

- The state is now positioned to extend that policy conversation and consider additional interventions that may reduce the severity of the problem. And this can be pursued with a much clearer understanding of the likely consequences of various approaches to address the problem of having almost 3 million Floridians without health insurance coverage.

* Highlights from the Florida Health Insurance Study, November 2004.

The Current Health Care Crisis. As indicated above, the current health care crisis in Leon County, as well as the state as a whole, is fueled primarily by rapidly escalating costs of health insurance that is forcing many businesses to cease providing health insurance benefits for their employees.

- The primary method by which most individuals acquire health insurance is through their employer's employee group insurance benefit programs (91 percent of insured). Only 9 percent of the people with health insurance buy their insurance as individual policies. Thus, the ability of businesses to offer health insurance benefits to their employees is critical to maintaining an insured population.

- A 2002 survey of Florida businesses by the Florida Chamber of Commerce found that:

  - Only 76 percent of Florida employers offered health insurance benefits to their employees. Based on prior Chamber surveys, the 76 percent rate of employers is down from 77 percent in 2001, 86 percent in 2000, and 91 percent in 1999.

- Thirty-five percent of the businesses dropped their coverage or experienced premium increases they could not afford.

- Fifty-five percent of employers who were unable to offer health insurance benefits cited high costs or limited access to group health insurance as the reason.

- Over the previous 12 months, 86 percent of employers experienced an increase in premiums. Of these, 47 percent endured a greater than 20 percent increase.

- Forty-two percent of the employers indicated that they will be forced to consider eliminating health insurance benefits if they experience further increases in premiums.

- Since 1999, health insurance costs across the nation have increased an estimated 54.3 percent, with the annual percentage increases rising each year from 8.3 percent in 2000 to 13.9 percent in 2005.

- National research indicates that for each 1.0 percent increase in health insurance costs, 0.084 percent of the population lose their health insurance. Applying this ratio to Leon County indicates that the 13.9 percent increase in insurance costs in 2005, alone, resulted in an estimated 2,452 County residents losing their health insurance.

- Small businesses are especially vulnerable to increases in health insurance costs because of the size of their employee groups and their generally low profitability levels. Since 94.8 percent of the County's businesses are small businesses (with fewer than 50 employees), Leon County's insured employees are at greater risk of losing their health insurance.

- Currently, an estimated 18,887 of Leon County's 245,280 under age 65 population have no health insurance and are not eligible for any publicly funded program.

- An estimated 21,843 of Leon County residents have an annual income of less than 200 percent of the federal poverty level, which is only about $19,350 per year for a family of four.

- An estimated 15,109 of the County's uninsured population will seek medical care in 2005 and will be unable to fully pay for those services. As a result, the County's hospitals and other health care providers will experience an estimated uncompensated cost of $20,835 million in 2005.

- The County's hospitals and other health care providers have no choice other than to pass their uncompensated costs on to insurance payers if they are to stay in business. Thus, in 2005, the uncompensated costs passed on to, primarily, insurance payers will be approximately $20,835,189. This $20,835,189 represents an "**invisible tax**" that is charged on insurance policies to cover the uncompensated costs of treating low income, uninsured patients.

- Only about 213,755 (81 percent) of the County's 263,896 population have health insurance. Thus, the "**invisible tax**" is currently being paid by only about 81 percent of the County's residents (primarily the employers of the 81 percent). The cost of the "**invisible tax**" is currently approximately $97 per insured person per year. For a small employer with 15 employees with employer paid health insurance benefits for employees only, the estimated annual "**invisible tax**" is $1,455.

Crisis to Become Much Worse. While the health insurance crisis is already a major problem for the County's businesses that have to pay the growing "**invisible taxes,**" for those employees who have lost their insurance and the health care providers who are having to shoulder the burden of rapidly growing uncompensated costs, the crisis will become far worse over the next ten years if corrective actions are not taken. Conservative estimates indicate that, under current conditions, health insurance premiums will grow at about 10 percent per year for the next ten years.

A vicious cycle has been set in motion whereby increased costs of health insurance premiums lead to more uninsured residents, which leads to higher uncompensated costs ("**invisible taxes**"), which leads to more uninsured residents, which leads to higher insurance premiums; and the cycle continues to worsen. Without corrective action to break the cycle:

- The estimated number of **uninsured residents** in Leon County **will grow** from the current (2005) level of 18,887 to 34,374 in 2015.

- The estimated number of low income, **uninsured patients** seeking care primarily from the County's hospitals **will grow** from 16,133 in 2004 to 22,586 in 2014.

- The estimated annual **uncompensated cost ("invisible tax")** of medical care **will grow** from $20,800,000 million in 2005 to $41,184,000 million in 2014.

- During the same time period, however, the estimated number of **insured** residents **will decline** from 229,226 in 2004 to 203,676 in 2014.

- The result will be a rapid growth in the **"invisible tax"** per insured resident from an estimated $97 in 2004 to $202 in 2014. An employer with 15 employees will experience an increase in the estimated annual "invisible tax" from $1,455 in 2004 to $3,030 in 2014.

- During the 10-year period, an estimated 32,090 County residents will lose their health insurance due to the cost for insurance becoming higher than they and their employers can afford.

Problems with the Current Health Care Delivery System for Low Income, Uninsured Residents. The current system in Leon County for delivering medical services to low income, uninsured residents who have no medical home, like **Bond Community Health Center** or **Neighborhood Health Services**, is unnecessarily expensive. In addition, the delivery of care does not adequately entail preventive and consistent treatment. The system can be characterized as an "isolated encounter-based" delivery system where low income, uninsured patients:

- Primarily use the hospital emergency rooms for most, if not all, of their medical care needs. Because emergency rooms are designed, equipped, and staffed to treat major medical emergencies, they are much more expensive places to receive primary care treatments than physician offices. Data from the County's two hospitals show that over 30% of the annual emergency room visits by low income, uninsured patients are not emergencies and could be treated in a physician office at an 82.5 percent lower cost.

- Routinely postpone seeking medical treatment until the illness has progressed to a critical level, requiring greatly increased costs of treatment. This is especially true for patients with chronic diseases such as diabetes, asthma, hypertension, and cancer where early treatment could prevent disease progression, thereby enabling the person to continue working and preventing subsequent hospitalizations and medications.

- Frequently do not get prescriptions filled or comply with physician follow-up treatments, again, allowing their diseases to progress to the point where much more expensive treatments are required.

- Usually do not have a regular physician—i.e., "medical home" where their medical records are maintained. As a result, the continuity of care that is critical for quality care is not available, leading to lack of consistency of treatment and greater chances of disease progression.

Who are the Low Income, Uninsured Residents not Covered by a Publicly Funded Program? Low income, uninsured residents not eligible for publicly funded programs

are primarily the working adults (under age 65) who work for employers who do not offer health insurance benefits, the self employed, those with part-time jobs not eligible for employee benefits, and the unemployed who are seeking work.

Publicly funded health care programs are limited primarily to Medicare, which covers individuals over the age of 65; Medicaid, which primarily covers low income individuals with severe disabilities and low income pregnant women; and KidCare programs which cover children from low income, uninsured families. No publicly funded primary medical care programs currently exist for low income, uninsured adults under age 65 who are not severely handicapped or are not pregnant.

Alternative Business Models for Delivering Health Care to Low Income, Uninsured Patients. Because national reform of health care delivery is not on the near-term political agenda, communities across the country have begun to initiate organized programs to provide more efficient, higher quality medical care to their low income, uninsured residents and to reduce the "invisible tax" charged to insurance and private payers. Although every program has been designed specifically to operate within the unique environment of each community, four general delivery models have evolved:

- **Clinic Model.** In the Clinic Model, public monies are either allocated to a clinic to provide as much care as possible to low income individuals or contracted on a per unit basis. Besides serving uninsured individuals, the clinic may serve Medicare and Medicaid patients, thus providing greater continuity of care as patient eligibility changes and providing a broader financial base for the clinic. The clinic focuses on primary and preventive care. Specialty and hospital care are referred out as needed, but usually are not supported by clinic funds.

- **Comprehensive Managed Care Model.** In the Comprehensive Managed Care Model, an organizational unit receives public funds to manage the health care program for low income, uninsured residents. The organization contracts with clinics, and providers on a per encounter or per member per month basis. Specialty, hospital, and other potential services such as dental are contracted also. Collectively, these service networks provide comprehensive care and case management for primary and preventive—as well as urgent and chronic illness—care.

- **Volunteer Model.** In the Volunteer Model, an extensive network of providers willing to volunteer their services is organized to provide charity care throughout the community. Referrals are coordinated to avoid overburdening providers. Primary care and specialty providers may offer services in clinics or private offices. Inpatient costs are covered by area hospitals. Area pharmacies may participate. The costs of the health care for low income, uninsured patients is

absorbed by providers primarily by charging higher costs to paying patients.

- **Insurance Model.** In the Insurance Model, an organization administers an insurance program with premiums from employers and/or patients and co-payments for services. Provider networks are formed and patients are assigned to a network for services. In some cases, public funds are used to subsidize the insurance costs.

Recommendations for Leon County. For those Leon County residents with annual incomes between 150 percent and 200 percent of the federal poverty level, the Community needs to develop or support private development of an insurance model under the Florida Health Flex program, which authorizes the sale of low cost/low benefit health insurance products. A Florida Health Flex program for Leon County would enable both employers and individuals to purchase affordable insurance which, when combined with lower cost hospitalization insurance, would provide a reasonable level of coverage to low income, uninsured residents. The PHIAB understands that a private health insurance provider is in process of developing a health care plan to address this segment of the population.

For those residents with annual incomes less than 150 percent of the federal poverty level who cannot afford to purchase low cost, low benefit health insurance, the Community should develop a Comprehensive Managed Care Model, which will effectively and efficiently meet the needs of this group of the County's population. The advantages of a managed care model include:

- provision of "medical homes" for all patients to ensure that they receive consistency of care to minimize disease and cost of treatment progressions;
- provision of health screening services to identify health problems early to prevent disease and cost of treatment progression;
- redirection of low income, uninsured patients to lower cost physician offices and clinics and away from the much higher cost hospital emergency rooms for primary medical care;
- utilization of existing providers, thereby providing broad geographical access to providers and avoiding the need to acquire, equip, and establish new facilities: and
- provision of an organizational unit to design and manage the delivery structure to include:
  - negotiations with medical providers to secure the most efficient delivery system;

- management of plan finances;
- management of medical provider issues.

- provision of a case management program to:
  - assess patient eligibility to ensure that only eligible patients are admitted to the program;
  - ensure that members who are eligible for other publicly funded programs use those programs first;
  - work to change patient habits of using hospital emergency rooms for primary health care to using lower cost physician offices;
  - guide patients to the most efficient and effective treatment centers;
  - assign patients to providers to ensure that no single provider is overloaded with low reimbursement patients;
  - discipline patients who do not meet plan requirements; and
  - maintain patient nonmedical records.

Services Provided by Managed Care Plan. The services provided by the managed care plan will be limited to annual health screenings and primary medical care with a limited formulary for pharmaceuticals. Hospitalization, organ transplants, and other expensive services are excluded.

Costs of Managed Care Plan. The estimated annual cost per patient member of the comprehensive health care plan should be evaluated and determined for the services provided.

Funding for a Managed Care Plan. The successful development of a community comprehensive care plan for providing efficient and effective managed care for low income, uninsured residents will require a reliable and continuing source of funds. The only reliable and continuing source of funds is a locally established tax. Many other communities in Florida have already established such taxes. In addition to other funding sources, the report recommends a thorough evaluation of a half-cent local option sales tax dedicated to funding health care for uninsured residents with annual incomes less than 150 percent of the federal poverty level. A half-cent sales tax will generate about $18 million per year and will provide adequate funding for the next 10 years.

Advantages to the People of Leon County. An organized and dedicated tax supported managed health care plan for serving the medical needs of low income, uninsured residents offers major advantages to both the County's insured and uninsured residents. The plan will:

- reduce the annual "invisible tax" paid by County employers who provide health insurance benefits to their employees.
- reduce the annual increases in health insurance costs.
- prevent the loss of health insurance due to cost increases for Leon County residents;
- after paying for the costs of the managed care plan, provide an annual saving to the community;
- transfer the primary care treatment away from expensive hospital emergency rooms to lower cost physician offices;
- prevent the hospitalization of a significant number of low income, uninsured patients; and
- provide a much higher quality of health care for low income, uninsured residents than they are currently receiving through the highly expensive hospital emergency rooms.

The plan also will significantly improve the level of health care received by low income, uninsured residents by:

- providing a "medical home" for the patients where medical records will be maintained and treatments can be provided on a consistent basis;
- providing sufficient resources to ensure that patients are able to comply with treatment requirements, thereby reducing illness progression;
- providing a chronic disease clinic for those patients with chronic diseases so as to reduce disease progression; and
- enabling patients to go back to work quicker by both healing illnesses quicker and reducing illness progression.

Collectively, these improvements will raise the overall status of health and quality of life in Leon County.

A
Proposed
"Strawman"

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Comprehensive Healthcare Services Model for Under and Uninsured Leon County Residents

1. Governance: Primary Responsible Organization

Create a 501(c) (3) nonprofit corporation with 15 board members including representatives from healthcare, civic and business communities to implement, plan, oversee, managed and administer the Leon County Comprehensive Healthcare Program for the Uninsured and Disadvantaged citizens. The County's Conflict of Interest Policies should be given consideration on the question of governance.

The Primary Responsible Organization (PRO) is responsible for the effective and efficient management of the Healthy Access comprehensive healthcare program for the uninsured and disadvantaged citizens of Leon County. The PRO shall make provisions for provider compensation; for healthcare services; and for administrative services.

2. Administration: Duties and Responsibilities

A. Shall screen all potential patients as per eligibility requirements as established.
B. Establish and maintain a quality network of healthcare providers.
C. Appropriately Identify eligible persons.
D. Assign patients to medical providers as appropriate.
E. Secure, maintain and service provider contracts.
F. Establish effective and efficient claim payment systems.
G. Establish effective and efficient reporting systems as directed by PRO.
H. Establish effective and efficient customer response system.

3. Covered lives: Uninsured and Disadvantaged:

The comprehensive healthcare program shall be limited to providing access to care for those persons with no access to insurance, do not have adequate personal resources, have annual family income at or below 150 percent of the most current non farm poverty level as established by the Federal Office of Management and Budget, does not work for an employer who offers health

insurance benefits, and are not eligible for any other publicly funded program and who maintain bona fide residence in Leon County.

Eligibility Requirements

Low Income, uninsured residents of Leon County
1. Income guidelines: Equal to or below 150% FPL
2. Not eligible for other publicly funded program
3. Not eligible for any other health insurance program
4. Children under 18 years of age not covered under any other public program
5. Cannot miss more than 2 consecutive appointments
6. Bona Fide resident of Leon County, ***with an intent to remain***
7. Limited Assets: Single Person $5000 or Les Two or more persons $6,000 or less Homestead and one vehicle exempted
8. Possess a valid for employment Social Security Card
9. Must be under age 65

4. "Up Front" Case Management "Navigators"

The Leon County Comprehensive Healthcare Program for the uninsured and disadvantaged shall provide for "up front" case management. Upon the patient's initial enrollment in the program, a nurse "Navigator", will conduct a detailed preliminary health assessment. The Navigator, in consultation with the Program Medical Director, will make referrals to other public programs or to medical providers as indicated by the health assessment. The Navigator will serve as the patient's point of contact with the health plan. The patient's first action is to contact the Navigator. The navigator will assess and analyze the need and make appropriate referrals.

The PRO will choose medically approved, Case management software with health assessment and medical decision criteria to assist the Navigator in appropriate referrals, maintaining medical standards and appropriateness of care.

5. The Comprehensive Healthcare Services program will offer the following basic care services:

- Physical examinations, health screenings, and immunizations;
- Diagnosis and treatment of individuals with acute illnesses, such as colds, otitis media, and influenza;

- Urgent care;
- Medical management of patients with chronic diseases, such as diabetes and hypertension;
- Referrals to other public programs as appropriate;
- Referrals to physician specialists for evaluation and consultation;
- Basic laboratory test;
- Routine X-Rays;
- Patient education on disease and health management;
- Low-cost pharmaceuticals as identified on an approved formulary;
- Basic dental services for adults;
- Referrals to mental health services and substance abuse intervention for evaluation and consultation and;
- Transportation services, where not personally available.

Comprehensive Healthcare Plan Services

1. Primary Care
• Emergency Care
• Urgent Care
• Up Front Medical Management
• Chronic disease medical Management
• Episodic outpatient care
• Periodic health assessment, including
- Health Examinations
- Medical history
- Physical examinations
- Necessary laboratory
X-Ray and other screening or diagnostic test as indicated by the age, sex, medical history, or physician examination
2. Other Physician Services Provided Through Program
• Limited consultations, examinations, and treatment specialties covered:
- Cardiology; Chiropractor, Dermatology, ENT, Gastroenterology, General Surgery, Gynecology, Nephrology, Neurology/Neurosurgery, Oncology, ophthalmology, Optometry, Orthopedic, Surgery, Podiatry, Psychiatry/Mental Health, Pulmonary, Urology.
3. Outpatient Surgical Services at Specialists Offices
4. Inpatient Hospital Services – *8 day Annual Limit*
5. Outpatient Diagnostic Services
- Hematology
- Chemistry
- Cytopathology

- MRI
- Eye Exam
- Cardiac Stress Test
- CT
- EKG
- Endoscopies and colonoscopies
6. Mamography Screening as Follows:
- A baseline Mammography for women ages 35 to 39
- A mammography for women ages 40 to 49 every 2 years or more frequently upon recommendation of Plan Physician
- A mammography every year for women age 50 to 64
- If a woman is more at risk for breast cancer due to family history, a history of biopsy-proven benign breast disease, a mother, sister, or daughter who has had breast cancer, or a woman who has not given birth before age 30
7. Hospital Based Physician Services
8. Outpatient Therapies
8. Physical and respiratory therapies provided at PCP Office only
9. Family Planning
9. Family planning limited to physician services for prescription
10. Adult Dental/Oral Surgery Services
11. Pharmaceuticals (Limited Formulary)
12. Transportation
13 Home Health and Durable Medical Equipment by Physician Order

6. The Leon County Comprehensive Healthcare Program will not provide the following services:

EXCLUDED SERVICES
• Infertility Services
• Prosthetic Devises
• Braces
• Oral Surgical Services
• Reconstructive Surgery
• Blood
• Organ Transplants
• Emergency Care and Services
• Ambulance Services
• Out-of –County Services
• Emergency Room

• Services not provided or arranged by an authorized PCP
• Skilled Nursing facility
• Any service or supply eligible to be paid for by another public program
• Services solely for personal comfort
• Treatment of learning disabilities, mental retardation, and other developmental disorders including, but not limited to, learning disorders, motor skills disorders, communication disorders, and autistic disorders.
• Items or services determined to be investigational or experimental in accordance with the standards of the AMA, the FDA, and the NIH.
• Services that are payable in part or in whole by any Workers' Compensation Act or similar law.
• Termination of pregnancy
• Occupational or speech therapy
• Hearing exams for persons over the age 17
• Acupuncture, Acupressure, hypnosis or biofeedback
• Services for the treatment of any kind of addiction
• Services who primary purpose is the treatment of sexual dysfunction, gender change, or treatment of gender identity, disorders, or medical or surgical treatment to improve or restore sexual function.
• Services or treatment provided by a person or facility which is not properly approved or licensed as required.
• Services or supplies not medically necessary
• Pre-conception testing or genetic testing
• Acupuncture/Homeopathic Alternative Medicine
• Advance Oncology
• Chiropractic Services
• Cosmetic/Plastic Surgery
• Dialysis (Chronic)
• Elective Vascular Surgery
• Hearing Aids/Testing
• Hospice Services
• Infertility Workups and Treatment
• Inpatient Rehabilitation Services
• Joint Replacements
• Nutritional Services
• Organ Transplants
• Orthodontia
• Outpatient Rehabilitation Services
• Procedures for the treatment of Obesity
• Prosthetic Appliances and Braces (Boots & Crutches only, no prosthetic

limbs.
• Skilled nursing care

7. Patients shall be charged co-pays as established by the PRO. *PRO will observe Income level sliding scale when establishing copays.* Individual providers will collect the co-pay at the time of the encounter. If the patient is unable to make the payment at the time of the encounter and has income at 50% or below the FPL, upon appropriate documentation, PRO will pay co-payment.

Health Service	Basic Care Program
Health Screenings	$0
Primary Care	
Acute Illness *(if Sliding Scale Permits)*	$10
Chronic Disease *(if Sliding Scale Permits)*	$5
Urgent Care	$10
Emergency	$50
Specialists	$10
Diagnostic Tests	
X-Ray	$15
Hematology	$5
Chemistry	$5
Cytopathology	$5
MRI	$25
Mammography	$5
Eye Exam	$10
Cardiac StressTest	$10
CT	$25
EKG	$10
Endoscopy and colonoscopy	$25
Outpatient Surgery	$50
Dental	
Exam	$15
Treatment	$15
Pharmaceuticals (30 Day Prescription)	
Generic	$5
Name Brand	$20
Mental Health	$10
Transportation	$0

8. Hospitals will charge co-pays per encounter to all emergency room users as a method of encouraging patients to use less costly providers for both urgent and Non-emergent care.

9. Payments to Primary Care Providers may be paid on a per member per month Basis and/or per encounter basis. Payment to all other providers will be on an encounter basis at levels at established Medicare rates.

10. Patient will be assigned (given patient preference) to all providers on a rotating Basis to evenly distribute the workloads among willing providers.

11. Healthy Access will maintain an ongoing quality assurance and continuous improvement program and will annually provide a status report to the community.